wisconsin Medicaid update and BadgerCare

March 2006 ● No. 2006-20

Wisconsin Medicaid and BadgerCare Information for Providers

To:

County Mental Health Coordinators

HealthCheck "Other Services" Providers

HMOs and Other Managed Care Programs

HealthCheck "Other Services" Child/Adolescent Day Treatment Services

This *Wisconsin Medicaid and BadgerCare Update* consolidates all of the information for child/adolescent day treatment services. Providers should use this *Update* in conjunction with the General Information section of the Mental Health and Substance Abuse Services Handbook and the All-Provider Handbook.

The purpose of this *Wisconsin Medicaid and BadgerCare Update* is to consolidate all of the information for child/adolescent day treatment services. This *Update* replaces the following child/adolescent day treatment publications:

- The October 2003 *Update* (2003-150), titled "Reduction of prior authorization requirements for child/adolescent day treatment, a HealthCheck 'Other Service.'"
- The July 2003 *Update* (2003-70), titled "Changes to local codes, paper claims, and prior authorization for child/adolescent day treatment, a HealthCheck Other Service, as a result of HIPAA."
- The October 1992 Medical Assistance Provider Bulletin (MAPB-092-002-Z), titled "WMAP Reimbursement for Intensive In-Home Treatment and Mental Health Day Treatment for Severely Emotionally Disturbed Children and Adolescents."

Providers should use this *Update* in conjunction with the General Information section of the Mental Health and Substance Abuse Services Handbook and the All-Provider Handbook.

HealthCheck "Other Services"

Child/adolescent day treatment services may be reimbursed by Wisconsin Medicaid when they are determined to be medically necessary to treat mental health needs identified during a HealthCheck screen. These services are covered under HealthCheck "Other Services." HealthCheck services are available to persons under age 21. All HealthCheck "Other Services," including child/adolescent day treatment, must be prior authorized.

Inside This Update:

Wisconsin Medicaid may cover services not described in the Medicaid state plan under HealthCheck "Other Services." Services that are included in the Medicaid state plan are not coverable as HealthCheck "Other Services." Refer to the General Information section of the Mental Health and Substance Abuse Handbook for further information on HealthCheck "Other Services."

Certification

To be reimbursed for providing child/adolescent day treatment services to Medicaid recipients, a provider is first required to be certified by the Department of Health and Family Services (DHFS), Division of Disability and Elder Services (DDES) for child/adolescent day treatment under HFS 40, Wis. Admin. Code. For information regarding this certification, providers may contact the DHFS, DDES by telephone at (608) 243-2025 or by mail at the following address:

Division of Disability and Elder Services
Bureau of Quality Assurance
Program Certification Unit
2917 International Ln Ste 300
Madison WI 53704

A provider meeting DHFS, DDES certification may initiate Medicaid child/adolescent day treatment provider certification by doing one of the following:

- Downloading the Wisconsin Medicaid Mental Health/Substance Abuse Agency Certification Packet from the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/*.
- Calling Provider Services at (800) 947-9627 or (608) 221-9883.
- Writing to the following address:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

Refer to Attachment 1 of this *Wisconsin Medicaid and BadgerCare Update* for more information about certification.

Refer to the General Information section of the Mental Health and Substance Abuse Services Handbook for more information about provider certification, provider numbers, and provider responsibilities.

Covered Services

Wisconsin Medicaid, under HealthCheck "Other Services," covers medically necessary child/adolescent day treatment services certified under HFS 40, Wis. Admin. Code. All services must be documented in the child's treatment plan. As documented in the child's treatment plan, appropriate clinical interventions that use social or recreational activities to augment the therapeutic process may be covered. If, based on the assessment, clinical interventions for difficulties with food or behaviors surrounding food are an integral part of a child's treatment plan, then child/adolescent day treatment services to address these needs may be covered.

Wisconsin Medicaid, under HealthCheck "Other Services," covers medically necessary child/adolescent day treatment services certified under HFS 40, Wis. Admin. Code.

Requirements

Child/adolescent day treatment services are covered when the following are present:

- Verification that a HealthCheck screen has been performed by a valid HealthCheck screener dated not more than one year prior to the requested first date of service (DOS).
- A physician's prescription/order dated not more than one year prior to the requested first DOS.
- Evidence of an initial multidisciplinary assessment that includes all elements described in HFS 40.09, Wis. Admin. Code, including a mental status examination and a five-axis diagnosis.

Wisconsin Medicaid reimburses up to five hours per day and 25 hours per week of medically necessary child/adolescent day treatment services.

- The individual meets one of the following criteria for a determination of "severely emotionally disturbed" (SED):
  - ✓ Is under age 21; emotional and behavioral problems are severe in degree; are expected to persist for at least one year; substantially interfere with the individual's functioning in his or her family, school, or community and with his or her ability to cope with the ordinary demands of life; and cause the individual to need services from two or more agencies or organizations that provide social services or treatment for mental health, juvenile justice, child welfare, special education, or health.
  - ✓ Substantially meets the criteria previously described for SED, except the severity of the emotional and behavioral problems have not yet substantially interfered with the individual's functioning but would likely do so without child/adolescent day treatment services.
  - ✓ Substantially meets the criteria for SED, except the individual has not yet received services from more than one system and in the judgment of the medical consultant, would be likely to do so if the intensity of treatment requested was not provided.
- A written multidisciplinary treatment plan signed by a psychiatrist or clinical psychologist as required in HFS 40.10, Wis. Admin. Code, that specifies the services that will be provided by the day treatment program provider, as well as coordination with the other agencies involved.
- Measurable goals and objectives that are consistent with the assessment conducted on the child and written in the multidisciplinary treatment plan.
- The intensity of services requested are justifiable based on the psychiatric assessment and the severity of the recipient's condition.

Services Provided via Telehealth

Individual child/adolescent day treatment services may be provided via Telehealth. Refer to the General Information section of the Mental Health and Substance Abuse Services Handbook for information about Telehealth requirements and claims submission.

Limitations

Wisconsin Medicaid reimburses up to five hours per day and 25 hours per week of medically necessary child/adolescent day treatment services.

Noncovered Services

The following services are not considered medically necessary and are not covered by Wisconsin Medicaid:

- Child/adolescent day treatment services occurring away from the child/adolescent day treatment program site, except crisis services provided by child/adolescent day treatment services staff to meet the acute needs of a client during periods when the client is not present at the day treatment program.
- Services that are primarily social or recreational.
- Break times between groups.
- Meal or snack times.
- Time spent in day treatment programs associated with educational activities, including homework time. Providers should coordinate these educational activities with their local education authority.

Documentation Requirements

Refer to Attachment 2 for documentation requirements for all mental health and

substance abuse service providers, including child/adolescent day treatment service providers. For additional information regarding documentation requirements, refer to the General Information section of the Mental Health and Substance Abuse Services section.

Wisconsin Medicaid reimburses the provision of services. Documenting the services provided is part of the provision of services.

Prior Authorization

All child/adolescent day treatment services require prior authorization (PA) before initiation of services. To request PA for child/adolescent day treatment services, providers will need to submit the following completed forms and required documentation to Wisconsin Medicaid:

- *Prior Authorization Request Form* (PA/RF), HCF 11018 (Rev. 10/03). The completion instructions and a sample PA/RF form are located in Attachments 3 and 4 and may also be downloaded from the Medicaid Web site.
- *Prior Authorization/Child/Adolescent Day Treatment Attachment* (PA/CADTA), HCF 11040 (Rev. 03/06). The completion instructions and PA/CADTA are located in Attachments 5 and 6 for photocopying and may also be downloaded and printed from the Medicaid Web site.
- Physician's prescription/order, dated not more than one year prior to the requested first DOS.
- Verification that a HealthCheck screen has been performed by a valid HealthCheck screener, dated not more than one year prior to the requested first DOS.
- Multidisciplinary child/adolescent day treatment plan.

Services are authorized based on the need for services as indicated in the clinical documentation supplied by the provider. Services cannot be authorized earlier than the date of the prescription or HealthCheck screen.

Refer to the General Information section of the Mental Health and Substance Abuse Services Handbook for information on backdating.

All child/adolescent day treatment services require prior authorization (PA) before initiation of services.

The Prior Authorization section of the All-Provider Handbook includes information on procedures for obtaining PA, including submitting PA requests via mail, fax, or the Web.

Claims Submission

Coordination of Benefits

Except for a few instances, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. Therefore, the provider is required to make a reasonable effort to exhaust all existing other health insurance sources before submitting claims to Wisconsin Medicaid or to state-contracted managed care organizations.

Refer to the Coordination of Benefits section of the All-Provider Handbook for more information about services that require other health insurance billing, exceptions, claims submission procedures for recipients with other health insurance, and the Other Coverage Discrepancy Report, HCF 1159 (Rev. 08/05). The Other Coverage Discrepancy Report is also available on the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/*.

Diagnosis Codes

All diagnoses must conform with the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) coding structure and must be allowable on the DOS. Claims received without an allowable ICD-9-CM code are denied.

Refer to Attachment 7 for a range of allowable diagnosis codes for child/adolescent day treatment services.

Procedure Codes

A Healthcare Common Procedure Coding System (HCPCS) code is required on all child/adolescent day treatment claims. Claims or adjustments received without a HCPCS code are denied. Refer to Attachment 7 for the allowable procedure code and modifier.

Place of Service Codes

Allowable place of service codes for child/adolescent day treatment services are included in Attachment 7.

Providers are encouraged to submit claims electronically since electronic claims submission usually reduces claim errors.

Electronic Claims Submission

Providers are encouraged to submit claims electronically since electronic claims submission usually reduces claim errors. Claims for child/adolescent day treatment services may be submitted using the 837 Health Care Claim: Professional transaction. Electronic claims may be submitted *except* when Wisconsin Medicaid instructs the provider to submit additional documentation with the claim. In these situations, providers are required to submit paper claims.

Refer to the Informational Resources section of the All-Provider Handbook for more information about electronic transactions.

Paper Claims Submission

Providers are required to submit paper claims for child/adolescent day treatment services using the CMS 1500 claim form dated 12/90. Wisconsin Medicaid denies claims for child/adolescent day treatment services submitted on any paper claim form other than the CMS 1500.

Wisconsin Medicaid does not provide the CMS 1500 claim form. The form may be obtained from any federal forms supplier.

Refer to Attachment 8 for CMS 1500 claim form instructions for child/adolescent day treatment services. Attachments 9 and 10 are samples of claims for child/adolescent day treatment services.

Information Regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *dhfs.wisconsin.gov/medicaid/*.

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ATTACHMENT 1
Certification Requirements for Child/Adolescent Day Treatment Services Provided by Agencies

This attachment outlines Wisconsin Medicaid certification requirements for Medicaid child/adolescent day treatment service providers. Prior to obtaining Wisconsin Medicaid certification, child/adolescent day treatment service providers are required to be certified by the Department of Health and Family Services (DHFS), Division of Disability and Elder Services (DDES), Bureau of Quality Assurance (BQA). County/tribal social or human services agencies that request billing-only status do not need to be certified by the DDES.

The following terms are used in the table:

- "Agency Providing the Service" — The agency whose staff actually performs the service.
- "Agency Only Allowed to Bill for the Service" — The agency that submits claims to Wisconsin Medicaid for the service. Only a county/tribal social or human services agency can be a billing agency. This agency does not perform the service but contracts with a provider to perform the service on the billing agency's behalf. The provider that is contracted is required to be Medicaid certified.

The following table lists required provider numbers and definitions for agencies providing child/adolescent day treatment services.

Definitions for Provider Numbers	
Type of Provider Number	**Definition**
Billing/Performing Provider Number	Issued to providers to allow them to identify themselves on claims as either the biller of services or the performer of services.
Billing-Only Provider Number	Issued to county/tribal social or human services agencies to allow them to serve as the biller of services when contracting with a service performer.

Type of Agency	**Certification Requirements**				**Type of Provider Number Assigned**
	Division of Disability and Elder Services/Bureau of Quality Assurance	**Wisconsin Medicaid**	**Section of Certification Packet to Be Completed***	**County/ Tribal Social or Human Services Agency Required?**	
Agency Providing the Service	The agency is required to obtain a DHFS certificate to provide child/adolescent day treatment services as authorized under HFS 40, Wis. Admin. Code (which meets Wisconsin Medicaid's HFS 105, Wis. Admin. Code requirement).	The agency is required to do the following: • Have a DDES, BQA certificate on file. • Complete and submit the Mental Health/Substance Abuse Agency Certification Packet.	Child/Adolescent Day Treatment Services (HealthCheck "Other Services")	No	HealthCheck "Other Services" billing/ performing provider number
Agency Only Allowed to Bill for the Service	Not required	The agency is required to complete and submit a Mental Health/Substance Abuse Agency Certification Packet to be a billing-only provider for child/adolescent day treatment. An allowable Medicaid performing provider is required to perform the service.	Child/Adolescent Day Treatment Services (HealthCheck "Other Services")	Yes	HealthCheck "Other Services" billing-only provider number

*This is a section of the Medicaid Mental Health/Substance Abuse Agency Certification Packet.

ATTACHMENT 2
Mental Health and Substance Abuse Services Documentation Requirements

Providers are responsible for meeting Medicaid's medical and financial documentation requirements. Refer to HFS 106.02(9)(a), Wis. Admin. Code, for preparation and maintenance documentation requirements and HFS 106.02(9)(c), Wis. Admin. Code, for financial record documentation requirements.

The following are Wisconsin Medicaid's medical record documentation requirements (HFS 106.02[9][b], Wis. Admin. Code) as they apply to all mental health and substance abuse services. In each element, the applicable administrative code language is in parentheses. The provider is required to include the following written documentation in the recipient's medical record, as applicable:

1. Date, department or office of the provider (as applicable), and provider name and profession.
2. Presenting Problem (chief medical complaint or purpose of the service or services).
3. Assessments (clinical findings, studies ordered, or diagnosis or medical impression).
   a. Intake note signed by the therapist (clinical findings).
   b. Information about past treatment, such as where it occurred, for how long, and by whom (clinical findings).
   c. Mental status exam, including mood and affect, thought processes — principally orientation X3, dangerousness to others and self, and behavioral and motor observations. Other information that may be essential depending on presenting symptoms includes thought processes other than orientation X3, attitude, judgment, memory, speech, thought content, perception, intellectual functioning, and general appearance (clinical findings and/or diagnosis or medical impression).
   d. Biopsychosocial history, which may include, depending on the situation, educational or vocational history, developmental history, medical history, significant past events, religious history, substance abuse history, past mental health treatment, criminal and legal history, significant past relationships and prominent influences, behavioral history, financial history, and overall life adjustment (clinical findings).
   e. Psychological, neuropsychological, functional, cognitive, behavioral, and/or developmental testing as indicated (studies ordered).
   f. Current status, including mental status, current living arrangements and social relationships, support system, current activities of daily living, current and recent substance abuse usage, current personal strengths, current vocational and educational status, and current religious attendance (clinical findings).
4. Treatment plans, including treatment goals, which are expressed in behavioral terms that provide measurable indices of performance, planned intervention, mechanics of intervention (frequency, duration, responsible party[ies]) (disposition, recommendations, and instructions given to the recipient, including any prescriptions and plans of care or treatment provided).
5. Progress notes (therapies or other treatments administered) must provide data relative to accomplishment of the treatment goals in measurable terms. Progress notes also must document significant events that are related to the person's treatment plan and assessments and that contribute to an overall understanding of the person's ongoing level and quality of functioning.

ATTACHMENT 3
Prior Authorization Request Form (PA/RF) Completion Instructions for Child/Adolescent Day Treatment Services

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. The Prior Authorization Request Form (PA/RF), HCF 11018, is used by Wisconsin Medicaid and is mandatory when requesting PA. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Providers may submit PA requests, along with the Prior Authorization/Child/Adolescent Day Treatment Attachment (PA/CADTA), HCF 11040, by fax to Wisconsin Medicaid at (608) 221-8616 or by mail to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

The words "HealthCheck Other Services" should be written in red ink across the top of the form. The quantity requested in Element 20 should be the total hours for the period requested, and the charges in Element 21 should be the total charges for the number of hours in Element 20. An *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description must be entered in Element 10 and, if applicable, Element 13.

SECTION I — PROVIDER INFORMATION

Element 1 — Name and Address — Billing Provider

Enter the name and complete address (street, city, state, and zip code) of the billing provider. The name listed in this element must correspond with the Medicaid provider number listed in Element 4. *No other information should be entered in this element, since it also serves as a return mailing label.*

Element 2 — Telephone Number — Billing Provider

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Element 3 — Processing Type

Enter the processing type "129" for medical day treatment. The processing type is a three-digit code used to identify a category of service requested. Prior authorization requests will be returned without adjudication if no processing type is indicated.

Element 4 — Billing Provider's Medicaid Provider Number
Enter the eight-digit Medicaid provider number of the billing provider. The provider number in this element must correspond with the provider name listed in Element 1.

SECTION II — RECIPIENT INFORMATION

Element 5 — Recipient Medicaid ID Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the recipient's Medicaid identification card or the Medicaid Eligibility Verification System (EVS) to obtain the correct identification number.

Element 6 — Date of Birth — Recipient
Enter the recipient's date of birth in MM/DD/YY format (e.g., September 8, 1966, would be 09/08/66).

Element 7 — Address — Recipient
Enter the complete address of the recipient's place of residence, including the street, city, state, and zip code. If the recipient is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 8 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 9 — Sex — Recipient
Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 10 — Diagnosis — Primary Code and Description
Enter the appropriate ICD-9-CM diagnosis code and description most relevant to the service or procedure requested.

Element 11 — Start Date — SOI (not required)

Element 12 — First Date of Treatment — SOI (not required)

Element 13 — Diagnosis — Secondary Code and Description
Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable.

Element 14 — Requested Start Date
Enter the requested start date for service(s) in MM/DD/YY format, if a specific start date is requested. If backdating is requested, include the clinical rationale for starting before PA was received. Backdating is not allowed on subsequent PA requests.

Element 15 — Performing Provider Number (not required)

Element 16 — Procedure Code
Enter the appropriate procedure code for each service requested.

Element 17 — Modifiers
Enter the modifier(s) corresponding to the procedure code listed.

Element 18 — POS
Enter the appropriate two-digit place of service code designating where the requested service would be provided.

Element 19 — Description of Service
Enter a written description corresponding to the appropriate Healthcare Common Procedure Coding System code for each service requested.

Element 20 — QR
Enter the appropriate quantity (e.g., number of services) requested for the procedure code listed.

Element 21 — Charges
Enter the usual and customary charge for each service requested. If the quantity is greater than "1," multiply the quantity by the charge for each service requested. Enter that total amount in this element.

Note: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to the provider *Terms of Reimbursement* issued by the Department of Health and Family Services.

Element 22 — Total Charges
Enter the anticipated total charge for this request.

Element 23 — Signature — Requesting Provider
The original signature of the provider requesting this service must appear in this element.

Element 24 — Date Signed
Enter the month, day, and year the PA/RF was signed (in MM/DD/YY format).

Do not enter any information below the signature of the requesting provider — this space is reserved for Wisconsin Medicaid consultants and analysts.

ATTACHMENT 4
Sample Prior Authorization Request Form (PA/RF) for Child/Adolescent Mental Health Day Treatment Services

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11018 (Rev. 10/03)

HealthCheck Other Services

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code

WISCONSIN MEDICAID
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read your service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

FOR MEDICAID USE — ICN	AT	Prior Authorization Number

SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code)	2. Telephone Number — Billing Provider	3. Processing Type
I.M. Provider **1 W. Wilson** **Anytown, WI 55555**	**(XXX) XXX-XXXX**	**129**
	4. Billing Provider's Medicaid Provider Number **12345678**	

SECTION II — RECIPIENT INFORMATION

5. Recipient Medicaid ID Number	6. Date of Birth — Recipient (MM/DD/YY)	7. Address — Recipient (Street, City, State, Zip Code)
1234567890	**MM/DD/YY**	**609 Willow** **Anytown, WI 55555**
8. Name — Recipient (Last, First, Middle Initial)	9. Sex — Recipient	
Recipient, Im A	**X** ☐ M ☐ F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description	11. Start Date — SOI	12. First Date of Treatment — SOI
313.81 — oppositional defiant disorder		
13. Diagnosis — Secondary Code and Description	14. Requested Start Date	
N/A		

15. Performing Provider Number	16. Procedure Code	17. Modifiers 1	2	3	4	18. POS	19. Description of Service	20. QR	21. Charge
	H2012	**HA**				**11**	**Behavioral health day treatment per hour**	**10**	**XXX.XX**

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

22. **Total Charges**	**XXX.XX**

23. **SIGNATURE** — Requesting Provider	24. Date Signed
I.M. Provider	**MM/DD/YY**

FOR MEDICAID USE Procedure(s) Authorized: Quantity Authorized:

☐ Approved _____ Grant Date _____ Expiration Date

☐ Modified — Reason:

☐ Denied — Reason:

☐ Returned — Reason:

_____ **SIGNATURE** — Consultant / Analyst _____ Date Signed

ATTACHMENT 5
Prior Authorization/Child/Adolescent Day Treatment Attachment (PA/CADTA) Completion Instructions

(A copy of the Prior Authorization/Child/Adolescent Day Treatment Attachment [PA/CADTA] Completion Instructions is located on the following pages.)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / CHILD / ADOLESCENT DAY TREATMENT ATTACHMENT (PA/CADTA) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all of the same information and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Providers should refer to the service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Attach the completed Prior Authorization/Child/Adolescent Day Treatment Attachment (PA/CADTA), HCF 11040, the physician prescription/order, evidence of a HealthCheck screen, and required documentation to the Prior Authorization Request Form (PA/RF), HCF 11018, and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616 or by mail to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

GENERAL INSTRUCTIONS

The information contained in this PA/CADTA will be used to make a decision about the amount of child/adolescent day treatment that will be approved for Medicaid reimbursement. Complete each section as completely as possible. Where noted in these instructions, the provider may attach material from his or her records.

Initial Prior Authorization Request
Complete the PA/RF and the entire PA/CADTA and attach the HealthCheck referral and physician order dated not more than one year prior to the requested first date of service (DOS). Label all attachments (e.g., “Day Treatment — Treatment Plan”). The initial authorization will be for a period of no longer than three months.

First Reauthorization
Complete the PA/RF and Sections I-III of the PA/CADTA. Attach a physician order for day treatment and a copy of the HealthCheck verification dated not more than one year prior to the requested first DOS. These materials may be copies of those included with the initial authorization request. Attach a summary of the treatment to date and any revisions to the day treatment services plan. Note progress on short- and long-term goals from the original plan. Be explicit in the summary as to the need for continued day treatment services. Authorization will be for a period of no longer than three months.

Second Reauthorization
Complete the PA/RF and Sections I-III of the PA/CADTA. Attach a copy of the physician order for day treatment and a copy of the HealthCheck verification dated not more than one year prior to the requested first DOS. These materials may be copies of those included with the previous authorization requests. Summarize the treatment since the previous authorization. The need for continued day treatment must be clearly documented. Where no change is noted in the treatment summary, justify the continued use of day treatment or note how changes in the treatment plan address the lack of progress. Specifically address aftercare planning. Authorization will be for a period of no longer than three months.

Subsequent Reauthorizations
Complete the PA/RF and Sections I-III of the PA/CADTA. Attach a copy of the physician order for day treatment and a copy of the HealthCheck verification dated not more than one year prior to the requested first DOS. These materials may be copies of those included with the previous authorization request. Attach a summary of the treatment since the previous authorization. Address why the recipient has not made transition to aftercare services. Strong justification will be required for day treatment services exceeding nine months per episode of treatment.

Check the appropriate box at the top of the PA/CADTA to indicate whether this request is an initial authorization, first reauthorization, second reauthorization, or subsequent reauthorization request. Make sure that the appropriate materials are included for the type of request indicated.

Multiple Services
When a recipient will require PA for other services concurrent to the child/adolescent day treatment (e.g., in-home treatment), a separate PA request must be submitted for those services along with the appropriate PA attachment and all required materials. The coordination of these concurrent services needs to be clearly indicated within the clinical documentation for all services. Other services must be identified on the multidisciplinary treatment plan(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial, exactly as it appears on the recipient's Medicaid identification card.

Element 2 — Age — Recipient
Enter the age of the recipient in numerical form (e.g., 16).

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number exactly as it appears on the recipient's Medicaid identification card.

SECTION II — PROVIDER INFORMATION

Element 4 — Name — Day Treatment Provider
Enter the name of the Medicaid-certified day treatment provider that will be billing for the services.

Element 5 — Day Treatment Provider's Medicaid Provider Number
Enter the eight-digit Medicaid provider number for the day treatment provider. Providers will be assigned a unique provider number for the child/adolescent day treatment program.

Element 6 — Name — Contact Person
Enter the name of a person who would be able to answer questions about this request.

Element 7 — Telephone Number — Contact Person
Enter the telephone number of the contact person.

SECTION III — DOCUMENTATION

Element 8
Indicate the requested start date and end date for the authorization period. See the general instructions for information on the length of authorization that will be generally allowed. If the requested start date is prior to when the PA request will be received by Wisconsin Medicaid and backdating is needed, specifically request backdating and state clinical rationale for starting services before authorization is obtained. Requests may be backdated up to 10 working days on the initial authorization if appropriate rationale is provided.

Element 9
Indicate the total number of hours for which the provider is requesting Medicaid reimbursement for this PA grant period. The total number of hours should equal the quantity requested in Element 20 of the PA/RF.

Element 10

Present or attach a summary of the diagnostic assessment and differential diagnosis. Diagnoses on all five axes of the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) are required. The assessment should address the level of reality testing, thought processes, drive control, relational capacity, and defensive functioning. Not all Medicaid-covered child/adolescent day treatment services are appropriate or allowable for all diagnoses. Professional consultants base approval of services on a valid diagnosis, acceptable child/adolescent day treatment practice, and clear documentation of the probable effectiveness of the proposed service. **Providers may attach a copy of a recent diagnostic assessment.**

Note: A substance abuse assessment may be included. A substance abuse assessment must be included if substance abuse-related programming is part of the recipient's treatment program.

Element 11
If the recipient is on psychoactive medication, the treatment plan must include the name of the physician managing the medication(s). Describe or attach a summary of the recipient's illness/treatment/medication history. For individuals with significant substance abuse problems, the multidisciplinary treatment plan should indicate how these will be addressed. *Providers may attach copies of illness/treatment/medication histories that are contained in their records.*

Element 12
Complete the checklist to determine whether an individual meets the criteria for severe emotional disturbance (SED).

a. List the primary diagnosis and diagnosis code in the space provided. Not all Medicaid-covered child/adolescent day treatment services are appropriate or allowable. Professional consultants base approval of services on a valid diagnosis, acceptable child/adolescent practice, and clear documentation of the probable effectiveness of the proposed service. Federal regulations do not allow federal funding of rehabilitation services, such as child/adolescent day treatment or in-home or outpatient mental health and substance abuse services, for persons with a sole or primary diagnosis of a developmental disability or mental retardation.

b. Complete the checklist for determining whether an individual would substantially meet the criteria for SED.

c. Check all applicable boxes. The individual must have one symptom or two functional impairments.

1. **Symptoms**
   - Psychotic symptoms — Serious mental illness (e.g., schizophrenia) characterized by defective or lost contact with reality, often with hallucinations or delusions.
   - Suicidality — The individual must have made one attempt within the last three months or have had significant ideation about or have made a plan for suicide within the past month.
   - Violence — The individual must be at risk for causing injury to persons or significant damage to property as a result of emotional disturbance.

2. **Functional Impairments (compared to expected developmental level)**
   - Functioning in self care — Impairment in self care is manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes, and meeting of nutritional needs.
   - Functioning in the community — Impairment in community function is manifested by a consistent lack of age-appropriate behavioral controls, decision making, judgment, and a value system that result in potential or actual involvement in the juvenile justice system.
   - Functioning in social relationships — Impairment of social relationships is manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.
   - Functioning in the family — Impairment in family function is manifested by a pattern of significantly disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness), inability to conform to reasonable limitations, and expectations that may result in removal from the family or its equivalent.
   - Functioning at school/work — Impairment in any *one* of the following:
     - ✓ Impairment in functioning at school is manifested by the inability to pursue educational goals in a normal time frame, such as consistently failing grades, repeated truancy, expulsion, property damage, or violence toward others.
     - ✓ Impairment at work is the inability to be consistently employed at a self-sustaining level, such as the inability to conform to work schedule, poor relationships with a supervisor and other workers, or hostile behavior on the job.

d. Check all applicable boxes:

The individual is receiving services from two or more of the following service systems:

- Mental health.
- Social services.
- Child protective services.
- Juvenile justice.
- Special education.

Eligibility criteria are waived under the following circumstance.

- Individual substantially meets the criteria for SED except the severity of the emotional and behavioral problems have not yet substantially interfered with the individual's functioning but would likely do so without child/adolescent day treatment services. Attach explanation.
- Substantially meets the criteria for SED except the individual has not yet received services from more than one system and in the judgment of the medical consultant, would be likely to do so if the intensity of treatment requested was not provided.

Element 13
Describe the treatment program that will be provided. Participation in specific groups/activities must be justified by the treatment plan. Attach a summary/description of groups or program components. The information presented should be adequate for determining that those services for which reimbursement is requested are Medicaid reimbursable.

Element 14
If not previously addressed, indicate the rationale for day treatment as opposed to other treatment modalities. If less intensive outpatient (clinic) services have not been provided, discuss why not. Providers should present this justification in their own words and not assume that the consultants can infer this from other materials presented with the request.

Element 15
Indicate the expected duration of day treatment. Describe services expected to be provided following completion of day treatment and transition plans. While providers are expected to indicate their expectations on the initial request, it is critical that plans for terminating day treatment be discussed in any requests for services at and beyond six months of treatment.

SECTION IV — ATTACHMENTS AND SIGNATURE

Element 16
The following materials must be attached and labeled.

a. Attach a copy of a physician's prescription/order dated not more than one year prior to the requested first DOS.

b. Attach verification that a HealthCheck screen has been performed by a valid HealthCheck screener not more than one year prior to the requested first DOS.

c. The treatment team must complete a multidisciplinary day treatment services plan. The plan must contain measurable goals, specific methods, and an expected time frame for achievement of the goals. The treatment plan must be tailored for the individual recipient.

The plan must clearly identify how specific program components relate to specific treatment goals. The documented methods should allow for a clear determination that the services provided meet criteria for Medicaid covered services. Services that are primarily social or recreational in nature, educational services, and mealtimes are not reimbursable.

d. Submit a copy of a substance abuse assessment if the psychiatric assessment indicates significant substance abuse problems and substance abuse-related services will be a part of the day treatment program. The assessment may be summarized in Element 10 as part of the psychiatric assessment or illness history. If the substance abuse problems will be addressed by some other agency, this should be indicated in the multidisciplinary treatment plan.

Element 17 — Signature — Day Treatment Program Director
The PA/CADTA request must be signed by the day treatment program director (psychologist or psychiatrist*).

Element 18 — Date Signed
Enter the month, day, and year the PA/CADTA was signed (in MM/DD/YYYY format).

* One who is licensed in Wisconsin and listed, or eligible to be listed, in the national register of healthcare providers in psychology.

ATTACHMENT 6
Prior Authorization/Child/Adolescent Day Treatment Attachment (PA/CADTA) (for photocopying)

(A copy of the Prior Authorization/Child/Adolescent Day Treatment Attachment [PA/CADTA] is located on the following pages.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11040 (Rev. 03/06)

WISCONSIN MEDICAID

PRIOR AUTHORIZATION / CHILD / ADOLESCENT DAY TREATMENT ATTACHMENT (PA/CADTA)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616 or by mail to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Child/Adolescent Day Treatment Attachment (PA/CADTA) Completion Instructions, HCF 11040A.

❑ Initial Request ❑ First Reauthorization ❑ Second Reauthorization ❑ Subsequent Reauthorization

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)	2. Age — Recipient
3. Recipient Medicaid Identification Number	

SECTION II — PROVIDER INFORMATION

4. Name — Day Treatment Provider	5. Day Treatment Provider's Medicaid Provider Number
6. Name — Contact Person	7. Telephone Number — Contact Person

SECTION III — DOCUMENTATION

8. Indicate the requested start date and end date for this authorization period. If the requested start date is earlier than the date the prior authorization request form is first received by Wisconsin Medicaid, specifically request backdating and state clinical rationale for starting services before prior authorization is obtained.

9. Indicate the number of hours of treatment to be provided over the PA grant period. Indicate the pattern of treatment (e.g., three hours per day, three days per week for eight weeks).

Continued

SECTION III — DOCUMENTATION (Continued)

The following additional information must be provided. If copies of existing records are attached to provide the information requested, *limit attachments to two pages for the psychiatric evaluation and illness / treatment history.* Highlighting relevant information is helpful. *Do not attach M-Team summaries, additional social service reports, court reports, or similar documents unless directed to do so following initial review of the documentation.*

10. Present a summary of the recipient's diagnostic assessment and differential diagnosis. The assessment should address the level of reality testing, thought processes, drive control, relational capacity, and defensive functioning. *Diagnoses on all five axes of the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM) are required.*

Continued

SECTION III — DOCUMENTATION (Continued)

11. Summarize the recipient's illness / treatment / medication history and other significant background information. Indicate why the provider thinks day treatment will produce positive change.

Continued

SECTION III — DOCUMENTATION (Continued)

12. Complete the checklist to determine whether an individual meets the criteria for severe emotional disturbance (SED). Criteria for meeting the functional symptoms and impairments are found in the instructions. *The disability must be evidenced by a, b, c, and d listed below.*

a. A primary psychiatric diagnosis of mental illness or severe emotional disorder. Document diagnosis using the most recent version of the American Psychiatric Association DSM.

_____
Primary Diagnosis Code and Description

b. **The individual must meet all three of the following conditions:**
- ❑ Individual is under the age of 21.
- ❑ Individual's emotional and behavioral problems are severe in nature.
- ❑ The disability for which the individual is seeking treatment is expected to persist for a year or longer.

c. **Symptoms and functional impairments**
The individual must have one of the following symptoms or two of the following functional impairments:

1. Symptoms
   - ❑ Psychotic symptoms.
   - ❑ Suicidality.
   - ❑ Violence.

2. Functional impairments
   - ❑ Functioning in self care.
   - ❑ Functioning in the community.
   - ❑ Functioning in social relationships.
   - ❑ Functioning in the family.
   - ❑ Functioning at school / work.

d. **The individual is receiving services from two or more of the following service systems:**
- ❑ Mental health.
- ❑ Social services.
- ❑ Child protective services.
- ❑ Juvenile justice.
- ❑ Special education.

Eligibility criteria are waived under the following circumstances:

- ❑ The individual substantially meets the criteria for SED, except that the severity of the emotional and behavioral problems have not yet substantially interfered with the individual's functioning but would likely do so without child/adolescent day treatment services. Attach an explanation.
- ❑ The individual substantially meets the criteria for SED, except that the individual has not yet received services from more than one system and, in the judgment of the medical consultant, would be likely to do so if the intensity of treatment requested was not provided.

13. Describe the treatment program that will be provided. Attach a day treatment program schedule, if available. Summarize the proposed intervention in this section. The treatment plan should specify how program components relate to this client's treatment goals.

Continued

SECTION III — DOCUMENTATION (Continued)

14. Indicate the rationale for day treatment. Elaborate on this choice if prior outpatient (clinic) treatment is absent or limited. Why does the recipient need this level of intervention at this time?

15. Indicate the expected date for termination of day treatment. Describe the anticipated service needs following completion of day treatment and the transition plan.

SECTION IV — ATTACHMENTS AND SIGNATURE

16. The following materials must be attached and *labeled:*

    a. A physician's prescription for day treatment services, signed by a physician, preferably a psychiatrist, dated not more than one year prior to the requested first date of service (DOS).
    b. Documentation that the recipient had a comprehensive HealthCheck screen dated not more than one year prior to the requested DOS. A copy of this documentation must be attached for reauthorizations. (A copy of the original documentation may be used.) *The initial request for these services must be received by Wisconsin Medicaid within one year of when the HealthCheck screen was dated.*
    c. A multidisciplinary day treatment services plan. The treatment plan must be signed by a psychiatrist or psychologist.* Per HFS 40.10(4), Wis. Admin. Code, a psychiatrist or Ph.D. psychologist shall sign the treatment plan, signifying the services identified in the plan are necessary to meet the mental health needs of the child. Revisions in treatment plans also need to be approved by the program psychiatrist or Ph.D. psychologist.
    d. A substance abuse assessment may be included. A substance abuse assessment *must* be included if substance abuse-related programming is part of the recipient's treatment program.

I attest to the accuracy of the information on this PA request.

17. **SIGNATURE** — Day Treatment Program Director	18. Date Signed

* One who is licensed in Wisconsin and listed, or eligible to be listed, in the national register of health care providers in psychology.

ATTACHMENT 7
Procedure Code Information for Child/Adolescent Day Treatment Services

The following table lists the Healthcare Common Procedure Coding System (HCPCS) procedure code and modifier that providers are required to use when submitting claims for child/adolescent day treatment services.

Allowable Child/Adolescent Day Treatment Place of Service Codes	
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
22	Outpatient Hospital

HCPCS Code	Description	Program Modifier	Allowable* ICD-9-CM** Diagnosis Codes	Maximum Allowable Fee Effective July 1, 2002	Copayment	Telehealth Services Covered?
H2012	Behavioral health day treatment, per hour	**HA** Child/adolescent program	290-316	$32.21/unit	None	For individual services only.

*The list of ICD-9-CM diagnosis codes for child/adolescent day treatment services is inclusive. However, not all Medicaid-covered child/adolescent day treatment services are appropriate or allowable. Professional consultants base approval of services on a valid diagnosis, acceptable child/adolescent practice, and clear documentation of the probable effectiveness of the proposed service. Federal regulations do not allow federal funding of rehabilitation services, such as child/adolescent day treatment or in-home or outpatient mental health and substance abuse services, for persons with a sole or primary diagnosis of a developmental disability or mental retardation.

**ICD-9-CM = *International Classification of Diseases, Ninth Revision, Clinical Modification*.

ATTACHMENT 8
CMS 1500 Claim Form Instructions for Child/Adolescent Day Treatment Services

Use the following claim form completion instructions, *not* the claim form's printed descriptions, to avoid denial or inaccurate Medicaid claim payment. Complete all required elements as appropriate. Do not include attachments unless instructed to do so.

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Medicaid Eligibility Verification System (EVS) to determine if there are any limitations on covered services and to obtain the correct spelling of the recipient's name. Refer to the Informational Resources section of the All-Provider Handbook or the Medicaid Web site for more information about the EVS.

Submit completed paper claims to the following address:

Wisconsin Medicaid
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

Element 1 — Program Block/Claim Sort Indicator

Enter claim sort indicator "P" in the Medicaid check box for the service billed.

Element 1a — Insured's I.D. Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the Medicaid identification card or the EVS to obtain the correct identification number.

Element 2 — Patient's Name

Enter the recipient's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 3 — Patient's Birth Date, Patient's Sex

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1990, would be 02/03/90) or in MM/DD/YYYY format (e.g., February 3, 1990, would be 02/03/1990). Specify whether the recipient is male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address

Enter the complete address of the recipient's place of residence, if known.

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name

Commercial health insurance must be billed prior to submitting claims to Wisconsin Medicaid, unless the service does not require commercial health insurance billing as determined by Wisconsin Medicaid.

If the EVS indicates that the recipient has dental ("DEN") insurance only or has no commercial health insurance, leave Element 9 blank.

If the EVS indicates that the recipient has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), TriCare ("CHA"), a health maintenance organization ("HMO") or some other ("OTH") commercial health insurance, *and* the service requires other insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three other insurance (OI) explanation codes *must* be indicated in the *first* box of Element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID by commercial health insurance or commercial HMO. In Element 29 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the recipient has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to: ✓ The recipient denied coverage or will not cooperate. ✓ The provider knows the service in question is not covered by the carrier. ✓ The recipient's commercial health insurance failed to respond to initial and follow-up claims. ✓ Benefits are not assignable or cannot get assignment. ✓ Benefits are exhausted.

Note: The provider may not use OI-D or OI-Y if the recipient is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not bill Wisconsin Medicaid for services that are included in the capitation payment.

Element 10 — Is Patient's Condition Related to (not required)

Element 11 — Insured's Policy, Group, or FECA Number

Use the *first* box of this element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Submit claims to Medicare before submitting claims to Wisconsin Medicaid.

Element 11 should be left blank when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- Wisconsin Medicaid indicates the recipient does not have any Medicare coverage for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A.
- Wisconsin Medicaid indicates that the provider is not Medicare enrolled.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

If none of the previous statements are true, a Medicare disclaimer code is necessary. The following Medicare disclaimer codes may be used when appropriate:

Code	Description
M-5	**Provider is not Medicare certified.** This code may be used when providers are identified in Wisconsin Medicaid files as being Medicare certified, but are billing for dates of service (DOS) before or after their Medicare certification effective dates. Use M-5 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part A. ✓ The procedure provided is covered by Medicare Part A. *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part B. ✓ The procedure provided is covered by Medicare Part B.
M-7	**Medicare disallowed or denied payment.** This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use M-7 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted. *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted.
M-8	**Noncovered Medicare service.** This code may be used when Medicare was not billed because the service is not covered in this circumstance. Use M-8 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is usually covered by Medicare Part A but not in this circumstance (e.g., recipient's diagnosis). *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is usually covered by Medicare Part B but not in this circumstance (e.g., recipient's diagnosis).

Elements 12 and 13 — Authorized Person's Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source (not required)

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use (not required)

Element 20 — Outside Lab? (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

Enter the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. The diagnosis description is not required.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number

Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Request Form (PA/RF), HCF 11018. Services authorized under multiple PA requests must be billed on separate claim forms with their respective PA numbers. Wisconsin Medicaid will only accept one PA number per claim.

Element 24A — Date(s) of Service

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one DOS, enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing for two, three, or four DOS on the same detail line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the "From" field, and enter subsequent DOS in the "To" field by listing *only* the date(s) of the month. For example, for DOS on December 1, 8, 15, and 22, 2005, indicate 12/01/05 or 12/01/2005 in the "From" field and indicate 08/15/22 in the "To" field.

It is allowable to enter up to four DOS per line if:

- All DOS are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All services have the same place of service (POS) code.
- All services were performed by the same provider.
- The same diagnosis is applicable for each service.
- The charge for all services is identical. (Enter the total charge *per detail line* in Element 24F.)
- The number of services performed on each DOS is identical.
- All services have the same family planning indicator, if applicable.
- All services have the same emergency indicator, if applicable.

Element 24B — Place of Service

Enter the appropriate two-digit POS code for each service. See Attachment 7 of this *Wisconsin Medicaid and BadgerCare Update* for a list of allowable POS codes for child/adolescent day treatment services.

Element 24C — Type of Service (not required)

Element 24D — Procedures, Services, or Supplies

Enter the appropriate procedure code for the service provided.

Modifiers

Enter the appropriate modifier in the "Modifier" column of Element 24D.

Element 24E — Diagnosis Code

Enter the number (1, 2, 3, or 4) that corresponds to the appropriate ICD-9-CM diagnosis code listed in Element 21.

Element 24F — $ Charges

Enter the total charge for each line item. Providers are required to bill Wisconsin Medicaid their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to Medicaid benefits.

Element 24G — Days or Units

Enter the appropriate number of units for each line item. Always use a decimal (e.g., 2.0 units). Use the rounding guidelines listed below.

Minutes Billed	Quantity
1-6	.1
7-12	.2
13-18	.3
19-24	.4
25-30	.5
31-36	.6
37-42	.7
43-48	.8
49-54	.9
55-60	1.0

Element 24H — EPSDT/Family Plan (not required)

Element 24I — EMG (not required)

Element 24J — COB (not required)

Element 24K — Reserved for Local Use

When the billing provider (Element 33) is a county/tribal social or human services agency "biller only" provider, enter the eight-digit individual performing provider number of the contracted agency providing the service. Otherwise, leave this element blank. Any other information entered in this element may cause claim denial.

Element 25 — Federal Tax I.D. Number (not required)

Element 26 — Patient's Account No. (not required)

Optional — Providers may enter up to 20 characters of the patient's internal office account number. This number will appear on the Remittance and Status Report and/or the 835 Health Care Claim Payment/Advice transaction.

Element 27 — Accept Assignment (not required)

Element 28 — Total Charge

Enter the total charges for this claim.

Element 29 — Amount Paid

Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Element 29 is greater than zero, "OI-P" must be indicated in Element 9.) If the commercial health insurance denied the claim, enter "000." Do *not* enter Medicare-paid amounts in this field.

Element 30 — Balance Due

Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28.

Element 31 — Signature of Physician or Supplier

The provider or the authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format.

Note: The signature may be a computer-printed or typed name and date or a signature stamp with the date.

Element 32 — Name and Address of Facility Where Services Were Rendered (not required)

Element 33 — Physician's, Supplier's Billing Name, Address, ZIP Code, and Phone

Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, street, city, state, and ZIP code. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

ATTACHMENT 9
Sample CMS 1500 Claim Form
for Child/Adolescent Day Treatment Services

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID [P] (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M [X] F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: WI

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX)XXX-XXXX

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? PLACE (State) ☐ YES ☐ NO

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 296.33
2. 300.3
3. ____
4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 7 07 05		22		H2012	HA	1	XXX XX	4.0				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE: $ XXX XX

29. AMOUNT PAID: $

30. BALANCE DUE: $ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED I.M. Authorized DATE MMDDYY

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555 87654321

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

ATTACHMENT 10
Sample CMS 1500 Claim Form
for Billing-Only Agencies

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) | MEDICAID ☐ (Medicaid #) | CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (VA File #) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY | SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown | STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (XXX)XXX-XXXX

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY | SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 296.33
2. 300.3
3. .
4. .

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24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 7 07 05		22		H2012	HA	1	XXX XX	4.0				12345678
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 1234JED

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28. TOTAL CHARGE: $ XXX XX

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I.M. Billing
1 W. Williams
Anytown, WI 55555 87654321

PIN# | GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)